NEBRASKA DDD/MLTC WAIVER WORKGROUP: HEALTH AND SAFETY
MARCH 17, 2016

Participants: Carla Lasley. Deb Rupe, Rose Wozny, Mary Schutt, Pam Hovis, Ladonaa Shippen, Donna Nickel, Sherry Jameson, Doshie Rodgers, Doug Raney, Ellen Mohling, Kathy Kay, Scott Hartz, Shelia Krolikowski, Michelle Waller, Darla Ramsey, Jessica Rooks, Kim Hall, Mary Conaway
Notes Recorder: Bernie Hascall
Next Meeting (date/time): 03/31/2016
Agenda:

- **Welcome**
- **Introductions**
- **Additions to the Agenda? Questions since we met last?**
- **Focus of the Health and Safety Work Group**
- **Understanding Appendix G Excel Sheets**
- **Next Steps**

Topic	Person Responsible	Discussion	Action Item
Data regarding the use of restraints	Scott/Bernie	The group requested Data on this. The group was looking for how often restraints are used.	Bernie & Scott to provide the group data regarding the use of restraints
Pervious DD regulations	Scott/Bernie	It was suggested that the group look in the old DD regulations regarding the use of restraint as well as check with the DD Council, as the Council may have some data that the group may find helpful as well.	Bernie & Scott to provide copies of previous NAC. Bernie to follow up with the DD Council for any data they may have in regard to the use of restraint.
Use of psychotropic meds for mental health needs as opposed to behavioral health needs.	Scott/Bernie	The group agreed on the need to look into the use of Chemical Restraints-Maybe some language which identifies if meds are based on mental health needs not just behavioral issues. We don't want to deny anyone appropriate treatment for behavioral health issues.	Bernie to reach out to the Division of Behavioral Health for some feedback or language regarding this topic.

Topic	Person Responsible	Discussion	Action Item
Appendix G-1	Work Group	G-1a Critical Event or Incident Reporting and Management Process G-1b State Critical Event or Incident Reporting Requirements G-1c Participant Training and Education G-1d Responsibility for Review of and Response to Critical Events or Incidents G-1e Responsibility for Oversight of Critical Incidents and Events	**G-1a:** Therap does record these, CMS did not have any issues or concerns: No additional group comments. **G-1b:** Look at the definitions. They are not consistent with the CMS language. DHHS is now using the core definitions and language as much as possible for the service definitions. Pam H. proposed that the group use CMS definitions and terminology. There may be differences between wording of current NAC and CMS- this is being addressed in the redesign. See provider timelines regarding Reporting Timelines. There were no concerns regarding the provider reporting timelines. No additional group comments. **G-1c:** This is completed through the handbooks and given to individuals and parents. See Kathy's Flow chart of APS investigations. There are some issues within the process in that information does not always flow well between the divisions (i.e. CFS, APS and SCs). This is an area to look into as far as stream lining the processes to ensure collaboration. **G-1d:** (G.1d & G.1e) These were both responded to similarly: CMS had no concerns on these as far as time line, the

Topic	Person Responsible	Discussion	Action Item
			work group was comfortable with the time lines. The work group expressed concerns over the oversight and supervision of non-specialized providers. How does this get accomplished with non-specialized providers? Currently this is handled by the SCs vs. on site investigation by the provider. Non specialized providers should not have more leeway. There needs to be a paper trail just like with specialized. In this situation APS would investigate. Is there a tracking process? What is the follow up to prevent this from happening again? Currently there is no correction piece in place. **G-1e:** see above.
Appendix G-2	Work Group	G-2a)i Safeguards Concerning the Use of Restraints G-2a)ii State Oversight Responsibility G-2b)I Safeguards Concerning the Use of Restrictive Interventions G-2b)ii State Oversight Responsibility G-2c) Detecting the use of unauthorized seclusion	**G-2.a)i:** The state provided CMS the definitions of Restraints and aversive stimuli….CMS did not have an issues with this. CMS did want Nebraska to clarify if Nebraska allows for the use of restraint. Regulations prohibit the use of restraint but policies allow for it. CMS is confused. The use of restraint will ultimately be a decision made by the Director as far as where we will go with this (i.e. will the use of restraint be allowed or not). The group requested Data on this. The group was looking for how often restraints are used. There was also discussion regarding how the Personal Emergency Safety

Topic	Person Responsible	Discussion	Action Item
			Interventions fit into this category- It was suggested that the group look in the old DD regulation as well as check with the DD Council, as the Council may have some data that the group may find helpful as well. Discussion then focused on Chemical Restraint. The use of Chemical Restraint must be approved by a physician. PRN psyche meds are not allowed at this time. In other states where they are, they are an issue. The group agreed on the need to look into the use of Chemical Restraints- Maybe some language which identifies if meds are based on mental health needs. We don't want to deny any one appropriate treatment for behavioral health issues. **G-2a)ii** CMS: issue: Time out/Separation issues. Documentation is typically through incident reports. Until we get better at reporting we need that oversight to review the incidents to ensure that they are categorized correctly. This is an ongoing training issue for provider staff. HRL looks at these types of interventions. There are plenty of restraints and restrictions in ISPs. Need to be tracking this. NDHHS used to report on things regarding consumer deaths, Abuse/Neglect etc. Those reports are stored. The formats will be changed. NDHHS is still collecting

Topic	Person Responsible	Discussion	Action Item
			the data. Maybe the behavioral health team could be looking at these reports like the nurses do the health reports. There will also be a need for this behavioral health team to be pulled in on behavioral health info. This can be tracked through the use of the MAR. There is also a baseline to track for psyche meds. **G-2b)i** See previous section comments. **G-2b)ii** See previous section comments. **G-2c** Previously restrictions and restraint were together versus in separate sections. Need to simplify and not repeat information here.
Appendix G-3	Work Group	G-3a Responsibility G-3b Methods of State Oversight and Follow-Up G-3c)i Provider Administration of Medications. G-3c)ii State Policy G-3c)iii Medication Error Reporting. G-3c)iv State Oversight Responsibility	**G-3a)** These regulations cross over to public health. Does the HLRC have to approve any and all psychotropic meds. This process could results in as much as a month delay in starting medications. The language does not give an option for a shorter approval process? Who gives the approvals? Normally the chair of the HLRC. How often does the HLRC shoot it down? Looks like a paper game. This is not a meaningful process. Additionally if there is an order for a med that we do not give then we are out of compliance. Look at this process for redesign as well as

Topic	Person Responsible	Discussion	Action Item
			monitoring psyche meds use and progress. Are we just medicating people? Let's reach out to the behavioral health field. The HLRC committee is only good as the people on the committee. Just can't be a providers. Nurse, pharmacy, parents. **G-3b)** Are SCs trained for this role? They look at if medication was given as prescribed, med errors, not looking at if that was an appropriate medication. GERs and monitoring tools is how this process is currently happening. How can the nurses be part of this process? Looks like SC are given monitoring responsibilities. Are they supported in this duty? What training do they have? **G-3c)1** Self Admin requirements: Those are in public health regulations. What is the oversight? In the public health regulations it describes who can be self-medicating? Who has the responsibility? The provider agency? What is the provider's exact responsibility? Does the person fill out a MAR? It is not in the Waiver or NAC 404. Is this an ongoing assessment? Should self-administration be treated like any other ADL? Still what is the provider's requirement?

Topic	Person Responsible	Discussion	Action Item
			G-3c)ii Med aide is unlicensed, not administering they are providing it. Look at the definition of med aide and medication administration. CMS issues: Med Errors: Confirm which state agencies can request reports- Therap provides a report regarding medication errors? Does Medicaid look at this - There is a rep on the QI committee. Public Health would look at the med error issues as well but as a point by point not in overall data. Current GER says the provider maybe put this in as a low GER. Harm or potential harm is a big piece here. **G-3c)iii** see previous section **G-3c)iv** SC monitoring issues identified above. The QI committee does this quarterly and annually.
Definitions	Work Group	Pam Hovis began the conversation requesting that the workgroup consider using the definitions identified by CMS. **Exploitation** **Restraint** **Emergency safety interventions** **Psychotropic Meds** **Physical injury** **Seclusion**	**The group offered the following thoughts:** **Exploitation:** Does it match APS language? Statute? How does this language fit with children? Exploitation could include non-consensual sex, photos, the current definition appears to focus on property/items? All APS definition should come over into the waivers regarding verbal abuse and physical abuse.

Topic	Person Responsible	Discussion	Action Item
			Restraint: Need clarification- Definition looks rights to the work group. Does this definition support the waiver language that the group would like it to? We still have an issue with PRN psychotropic medications and how these could be handled. **Emergency safety interventions**: Seclusion is prohibited. This is confusing. This was wrapped into restraint. This needs different language. The Emergency Safety Intervention is much broader than restraint. It might be better to rename the safety intervention since it is now so closely linked to restraint. **Psychotropic Meds**: These could be used to treat non mental health/behavioral health issues. Is there language which needs to be in the waiver/regulations that would reflect this use without going through the HLRC? **Physical injury**: No feedback provided. **Seclusion**: add language to reflect that if the person believes they are unable to leave that is also the use of seclusion.

Parking Lot issue:

- When we look at critical incident management system, we will need to rework this to make the data more consistent so we can pull usable and reliable data.
- Current issues with incident reports may be caused by the number of options to select from. We need a way to measure the % of GERS completed to see how many were actually done and categorized correctly.

Considerations for 2017: